

KANSAS MEDICAID STATE PLAN

PROVIDER NUMBER

SCHEDULE H STATEMENT OF RELATED ICF/MR HOME INFORMATION

461 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ICF-MR FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATIONS)?..... ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE I.
IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
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SCHEDULE G

REVENUE STATEMENT

	(1) REV PER BOOKS	(2) ADJUSTMENT TO	(3) LINE NUMBER
LN#	OR FED TAX RETURN	EXPENSE ACCOUNTS	OF RELATED EXP
ROUTINE DAILY SERVICE:			
PRIVATE PAY CLIENTS	431		
MEDICAID CLIENTS & PATIENT LIABILITY	432		
NOT APPLICABLE	433		
VETERAN ADMINISTRATION CLIENTS	434		
OTHER CLIENTS (SPECIFY) ()	435		
PHARMACY-DRUGS & MEDICATIONS	436		
NURSING SUPPLIES SOLD TO PRIVATE PAY CLIENTS	437		
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	438		
BEAUTY/BARBER SHOP	439		
CLIENT PURCHASES	440		
PURCHASE DISCOUNTS, RETURNS & ALLOWANCES	441		
OTHER SUPPLIES SOLD	442		
PROGRAM REIMBURSEMENTS & TAX CREDITS	443		
INVESTMENT/INTEREST INCOME	444		
VENDING MACHINE REVENUE	445		
DAY CARE/TREATMENT INCOME	446		
HEAVY CARE INCOME	447		
OTHER (SPECIFY)	448		
TOTALS	449		XXXXXXXXXXXXXXXXXX

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SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

481	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
482	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 493.			
	(1) NAME OF OWNERS OF PHYSICAL FACILITY	(2) % OF OWNERSHIP	(3) DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE IN "NONE"
485			
486			
487			
488			
489			
IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS CAREFULLY CONCERNING REQUIREMENTS FOR COMPLEX CAPITAL STRUCTURES.			
491	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED.			
492	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
493	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
494	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
(ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)			
495	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?..... <input type="checkbox"/> YES <input type="checkbox"/> NO			
496	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT?..... <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF NO, SUBMIT COPIES OF DOCUMENTS NOW			

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SCHEDULE J

PRIVATE PAY RATES

PROVIDE EACH PRIVATE PAY RATE CHANGE DURING THE FISCAL YEAR REPORTED. PROVIDE ATTACHMENT IF MORE SPACE IS NEEDED. BEGIN WITH CURRENT RATES.

EFFECTIVE DATE:	TYPE OF CARE	NF	ICF-MR	NF-MH
(MOST CURRENT RATES)	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
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	SEMI-PRIVATE RM			
	WARD			
	OTHER			
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			
	PRIVATE ROOM			
	SEMI-PRIVATE RM			
	WARD			
	OTHER			

1. HAVE YOU AND THE PREPARER SIGNED THE COST REPORT?

2. HAVE YOU COMPLETED ALL THE SCHEDULES?

3. HAVE YOU ATTACHED ALL REQUIRED SCHEDULES AND OTHER DOCUMENTS IN ACCORDANCE WITH THIS REPORT AND ITS INSTRUCTIONS?

4. HAVE YOU SUBMITTED TWO (2) COPIES OF THE COMPLETED COST REPORT AND ONE (1) COPY OF THE AU-3902 (CENSUS SHEETS)?

5. FAILURE TO COMPLETE AND SUBMIT THIS COST REPORT COULD RESULT IN A DELAY IN THE MEDICAID RATE PER

KAS 37.10-21A

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30-10-214 (1)

30-10-214. ICF-MR rates of reimbursement. (a) Rates for ICF's-MR.

(1) The determination of per diem rates shall be made, at least annually by the secretary, on the basis of the cost information supplied by the provider and retained for cost auditing. The cost information for each provider shall be compared with limits established based on the level of care needs of clients to determine the allowable per diem cost.

(2) Ownership allowance shall be determined as follows:

(A) All ICF's-MR initially certified to participate in the medicaid/medikan program prior to July 1, 1991 shall be held to the established ownership allowance.

(B) All ICF's-MR certified on or after July 1, 1991 shall be subject to an absolute cap on ownership costs.

(3) Per diem rates for the following cost centers shall be limited by absolute caps:

(A) The cost center limits shall be based on facility size and level of care. The cost centers and limiting factors are as follows:

(i) Direct service based on facility size and level of care. Direct service consists of the room and board and health care cost centers in the ICF-MR financial and statistical report.

(ii) Administration based on facility size.

(iii) Plant operating shall be based on total allowable costs.

(B) The absolute caps shall be reviewed at least annually for reasonableness based on the reimbursement model and the allowable historical costs. The absolute caps shall be approved by the secretary or a designated official.

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30-10-214 (2)

(4) To establish a per diem rate for each provider by facility size and level of care, a factor for inflation may be added to the allowable per diem cost. The per diem rate shall be based on the lower of the actual allowable cost or the absolute cost center limits. After the rate is established for a provider, a detailed listing of the computation of that rate shall be provided to the provider. The effective date of the rate for existing facilities shall be in accordance with subsection (a) of K.A.R. 30-10-215.

(b) Comparable service rate limitations.

(1) Intermediate care facilities for the mentally retarded and persons with related conditions. The per diem rate for intermediate care for the mentally retarded and persons with related conditions shall not exceed the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR and for the same types of services.

(2) All private pay rate structure changes and the effective dates shall be reported on the uniform cost report.

(3) The agency shall be notified of any private pay rate structure changes within 30 days of the effective date of a new medicaid rate.

(4) Providers shall have a grace period to raise the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR.

(A) The grace period shall end the first day of the third calendar month following notification of a new medicaid/medikan rate.

(B) The notification date is the date typed on the letter which informs the provider of a new medicaid/medikan rate.

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30-10-214 (3)

(C) There shall be no penalty during the grace period if the rate or rates charged to clients not under the medicaid/medikan program are lower than the medicaid/medikan rate.

(D) If the rate or rates charged to clients not under the medicaid/medikan program are lower than rates charged to medicaid/medikan clients after the grace period, the medicaid/medikan rate will be lowered as of the original effective date of the most recent changes.

(c) Rates for new construction or bed additions. The per diem rate or rates for newly constructed ICF's-MR shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-213. No rate shall be paid until an ICF-MR financial and statistical report is received and approved. Limitations established for existing facilities providing the same level of care shall apply. The effective date of the per diem rate shall be in accordance with K.A.R. 30-10-215.

(d) Change of provider.

(1) When a new provider makes no change in the facility, number of beds or operations, the interim payment rate for the first 12 months of operation shall be based on the historical cost data of the previous owner or provider. The new owner or provider shall file a 12-month historical cost report within three months after the end of the first 12 months of operation and another one within three months after the end of the provider's fiscal year established for tax or accounting purposes. The rates determined from these cost reports shall be effective in accordance with K.A.R. 30-10-215.

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30-10-214 (4)

(2) The agency may approve a new rate based on a projected cost report when the care of the clients is certified to be at risk by the Kansas department of health and environment because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

(e) Per diem rates with errors.

(1) When per diem rates, whether based upon projected or historical cost data, are audited by the agency and are found to contain errors, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may be made when a provider has more than one facility involved in settlements.

(2) Per diem rates for providers may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of these per diem rate changes and of the audit findings due to an audit shall be sent to the provider. Retroactive adjustments of rates paid during any projection period shall apply to the same period of time covered by the projected rates.

(3) Providers have 30 days from the date of the audit report cover letter to request an administrative review of the audit adjustments that result in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) Any audit exception imposed on the agency by the department of health and human services due to provider action may be recovered from the provider.

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30-10-214 (5)

(f) Provision of services out-of-state. Rates for clients served out-of-state by certified participants in a medicaid program shall be the rate or rates approved by the agency. All payments made for services provided outside the state of Kansas require prior authorization by the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

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Methods and Standards for Establishing Payment Rates

(ICF's/MR)

Classes of ICF's/MR and Levels of Care

Classes of ICF's/MR shall be either:

- I. State intermediate care facilities for the mentally retarded (class 1)
 - A. All facilities in Class 1 (state intermediate care facilities for the mentally retarded) will be reimbursed with a retrospective payment system. The annual cost reports filed by the state ICF's/MR will be used to determine the actual cost per day for services. A retroactive settlement will be determined for the time period covered by the cost report. The total allowable costs will be divided by the actual client days to determine the actual per diem rate. The variance between the actual per diem rate and the per diem rates paid during the report period will be multiplied by the paid client days to arrive at the annual settlement.
 - B. The prospective per diem rates will be determined by allowing an inflation factor to be applied to the costs from the previous reporting period.
 - C. An additional factor may be included in determining the prospective rates to account for expected changes in either the costs or resident days during the subsequent fiscal year. The additional projected per diem rate will be added to the prospective per diem rate determined from the last historic cost report on file. The prospective rate will not involve a complete projection of all costs and resident days. A retroactive settlement will be made in accordance with (A) above.